

FILED DEC 2 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39445

State File No.

BIRTH NO.		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>6076</u>		Registrar's No. <u>2862</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Jennings, Mo.</u>		c. LENGTH OF STAY (In this place) <u>4 mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>University City, Mo.</u>		4366	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Elms Convalescent Home</u>				d. STREET ADDRESS (If rural, give location) <u>8485 Kiemplin Pl.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Iona</u>		b. (Middle) <u>Russell</u>		c. (Last) <u>Russell</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>November 27, 1950</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Dec. 2, 1861</u>	
9. AGE (In years last birthday) <u>88</u>		10. MONTHS <u>11</u>		11. DAYS <u>25</u>		12. IF UNDER 1 YEAR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Alton, Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13a. FATHER'S NAME <u>Pious Hale</u>			
13b. MOTHER'S MAIDEN NAME <u>Margaret McKenna</u>				14. NAME OF HUSBAND OR WIFE <u>George Russell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Katherine Arlt, 2113 Prather Ave.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Cardiac vascular disease</u> DUE TO (c) <u> </u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Right mid thigh amputation</u> <u>Right hemiplegia</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>6 months</u>			
19a. DATE OF OPERATION <u> </u>				19b. MAJOR FINDINGS OF OPERATION <u> </u>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u> </u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u> </u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u> </u>	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u> </u>					
22. I hereby certify that I attended the deceased from <u>July 28, 1950</u> to <u>11/27, 1950</u> , that I last saw the deceased alive on <u>11/27, 1950</u> , and that death occurred at <u>3:20 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Leona Littmann MD</u>				23b. ADDRESS <u>8231 Clayton Road</u>		23c. DATE SIGNED <u>11/27/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11/29/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>	
DATE REC'D BY LOCAL REG. <u>11/27/50</u>		REGISTRAR'S SIGNATURE <u>Harold R. Dornier MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ambruster Mortuary, 6633 Clayton Rd.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed.....

Licensed Embalmer No. 3917

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.